Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH LLC
5445 LA SIERRA DR #204
DALLAS TX 75231

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
MESQUITE ISD

Carrier's Austin Representative Box
Box Number 04

MFDR Tracking Number
M4-09-7522-02

MFDR Date Received
APRIL 10, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Per TWCC Rule 133.301(a); Service was preauthorized."

Amount in Dispute: $6,750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As indicated on the explanations of review, the charges for thse services were denied on the basis that they were not medically necessary based on DD/RME report. The DD/RME report stated chronic pain management would not be necessary for the compensable injury. However, the claimant's condition did require chronic pain management (but not due to the compensable injury). Additionally, the preauthorization was limited to services between January 6, 2009 and January 30, 2009. Services performed outside the preauthorization dates are not reimbursable as they were not preauthorized. This MDR Request presents both an extent of injury and preauthorization issue. Respondent asks that the portion related to extent of injury be dismissed and the portion where preauthorization was exceeded be decided in the Respondent's favor."

Response Submitted by: Harris & Harris, PO Box 91569, Austin, TX 78709-1569

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 8, 2009 through February 4, 2009	CPT Code 97799-CP-CA	$6,750.00	$6,750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization of certain

services.

3. 28 Texas Administrative Code §134.204 set out reimbursement policies for workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 11, 2009, February 16, 2009, February 26, 2009, March 9, 2009
   - 50F – These are non-covered services because this is not deemed a 'medical necessity' by the payer. *Not medically necessary per designated doctor exam and/or required medical exam.*
   - 217A – Based on payer reasonable and customary fees. *No maximum allowable defined by legislated fee arrangement. Processed at the direction of the insurance carrier.*
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is there an extent of injury issue?
2. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
3. Did the requestor obtain preauthorization in accordance with 28 Texas Administrative Code §134.600(p)(10) and an extension of services in accordance with 28 Texas Administrative Code §134.600(q)(5)?
4. Is the requestor entitled to reimbursement in accordance with 28 Texas Administrative Code §134.204(h)(5)(A) and (B)
5. Is the requestor entitled to reimbursement?

Findings

1. According to the respondent's position summary, which states, "This MDR Request presents both an extent of injury and preauthorization issue. Respondent asks that the portion related to extent of injury be dismissed and the portion where preauthorization was exceeded be decided in the Respondent's favor." Review of both parties documentation and the Division's information system shows that a PLN-11 was not filed to dispute an extent of injury. On August 31, 2009 the Division spoke with the insurance carrier representative, Mr. Timothy White, at Harris & Harris and advised him the services rendered to the injured employee were for the compensable conditions and not the knee.
2. The requestor filed the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307; therefore, the services will be reviewed in accordance with Division rules and the Texas Labor Code.

3. According to the preauthorization approvals the original request for preauthorization was made on December 2, 2008 for the chronic pain management program for five times per week for two weeks. On January 6, 2008 [sic] Argus Services Corporation was contacted by James at Texas Health requesting an extension to begin and complete the Chronic Pain Management Program as the patient had not attended any sessions of the program due to child care and transportation issues. Argus preauthorized the extension date of service range to January 6, 2009 through January 30, 2009. On January 30, 2009 Anne with Texas Health requested an extension of one week as the patient missed two days of the program due to inclement weather. Argus approved extension through February 6, 2009. In accordance with 28 Texas Administrative Code §134.600(c)(1)(B)(C) The carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) of this section only when the following situations occur: preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care and concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care. Therefore, the denial of 50F – These are non-covered services because this is not deemed a 'medical necessity' by the payer. *Not medically necessary per designated doctor exam and/or required medical exam.* is not a valid denial.

4. Per 28 Texas Administrative Code §134.204(h)(5), the following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs: (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier and (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

5. Review of the submitted documentation finds that the requestor has submitted medical records to support the services were rendered as billed. Therefore, reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $6,750.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 6, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.